Appendix 9a
Prior Authorization Request Form (PA/RF) Completion Instructions (Physical Therapy)

See Appendix 10a of this handbook for Spell of Illness PA/RF instructions.

Element 1 - Processing Type
Enter processing type 111, Physical Therapy.

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate *International Classification of Disease, 9th Edition, Clinical Modification* (ICD-9-CM) diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Do not complete this element *unless* requesting a therapy (PT, OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Do not complete this element *unless* requesting a therapy (PT,OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS procedure code as described in the plan of care in this element.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. *Do not complete* this element if requesting a therapy (physical therapy) spell of illness.

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure requested.

Element 20 - Charges
Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

> *Note:* The charges indicated on the *request form* must reflect the provider's usual and customary charge for the procedure requested. Providers are paid for authorized services according to the Department of Health and Family Services' *Terms of Reimbursement.*

Element 21 - Total Charge
Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program.

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is used by Medicaid consultant(s) and analyst(s).